

Bridging the Gap: Addressing the Need for North Carolina to Accept the
Affordable Care Act's Medicaid Expansion in Order to Close the Gap Between
Medicaid and Private Insurance Coverage of its Uninsured Adult Population

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Abstract

The overall goal of this qualitative research study is to explore and explain North Carolina General Assembly's reasons for denying the Affordable Care Act's Medicaid expansion and its constituents' responses to this decision. This is a N.C. health policy issue focusing on the most vulnerable and disadvantaged population within the realm of this political healthcare debate which is: the gap coverage population consisting of uninsured, childless, working non-elderly adults who are too poor to afford private insurance and who do not qualify for Medicaid. This investigative study project attempts to answer the following questions: 1) Why does North Carolina need to accept the Affordable Care Act's (ACA) Medicaid Expansion? 2) How did the state's decision to deny Medicaid expansion impact the healthcare management of its uninsured adult population? Data was gathered through a literature review of publically related articles and audio recorded interviews from 10 informants residing within North Carolina's tri-county (Wake, Durham, Orange) and rural areas. Data analysis was completed by reviewing the transcribed audio recordings for common themes, new understandings, and interpretations concerning how North Carolina's rejection of Medicaid Expansion had affected its uninsured adult population. An integration and analysis of the perceptions of the participants revealed that nine out of 10 participants are in support of Medicaid Expansion. Nine out of ten participants reported that they knew of individuals who were personally affected by being within the gap between private and Medicaid insurance. Eight out of ten participants stated that they did not know of any current state level alternative insurance plans or changes in health policy made to accommodate those individuals within the gap population. These findings will help establish an evidence-based valid argument supporting the need for the NC General Assembly to accept Medicaid Expansion in order to close the gap between private insurance and Medicaid coverage.

Introduction

The lack of medical insurance is an important public health issue in the United States that poses significant health risks for the population and the overall healthcare system. With case management being an essential force in assuring that patients receive the proper resources to meet their healthcare needs, it is important to identify those patients who fall in the gap between receiving Medicaid and private insurance coverage. When North Carolina opted out of the Medicaid expansion, this created a gap in medical insurance coverage, which affected the poor and uninsured of all age ranges and races (North Carolina Justice Center, 2014). Since North Carolina's Medicaid program only serves low income adults with dependent children, seniors (age greater than 64), and the disabled (North Carolina Department of Human and Health Services [NCDHHS], 2015), Medicaid Expansion is needed in order to ensure that everyone has healthcare insurance. Medicaid Expansion would give tax credits to non-disabled adults without dependents and to those who do not qualify for Medicaid or Medicare. These tax credits are used to purchase insurance coverage in the new insurance marketplaces set up by each state (Henry J. Kaiser Family Foundation, 2013). This provision will provide health insurance for single or married hard working people with an annual income above and below 100% of the Federal Poverty Level equal to \$11,770 per year for a single individual (Federal Register, 2015). Medicaid expansion will cover single adults with annual incomes up to 138% of the Federal Poverty Level (FPL) (Library of Congress, 2015). In addition, North Carolina will receive billions of dollars in Federal Funding for expanding Medicaid. This will increase access to preventive medicine services and promote healthy outcomes within our healthcare system (USDHHS, 2015). North Carolina's refusal to expand Medicaid has also caused the closing of hospitals (UNC Cecil G. Sheps Center for Health Services Research, 2015), the loss of jobs, and

the loss of tax revenue (Ku, Bruen, Steinmetz, & Bysshe, 2014). These factors make refusing to expand Medicaid an ethical and detrimental public health issue, which needs to be addressed with urgency and aggressiveness in order to save our economy and millions of lives within North Carolina.

Literature Review

Background

There have been many Presidential attempts in the United States' history to ensure that every American has fair and equal access to healthcare. In 1965, President Lyndon Johnson signed into law the Social Security Act Amendments, known as Medicare, which gave healthcare benefits to the elderly age 65 and older (Social Security Administration [SSA], 2015). In 1972, President Richard Nixon's administration passed the Social Security Amendments extending Medicare to people of any age who are blind, disabled, and/or have end stage renal disease requiring kidney transplant and renal dialysis (Social Security Administration [SSA], 2015). In 1997, President Bill Clinton enacted the Children's Health Insurance Program (CHIP) legislation which helped states to insure low-income children whose families are ineligible for Medicaid and could not afford private insurance (Center for American Progress, 2015). In 2003, President George W. Bush passed the Medicare Modernization Act, known as Medicare Part D Program, which gave prescription drug discounts and subsidies to low income Medicare beneficiaries (Social Security Administration, 2015). In 2009, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), which allowed states to provide Medicaid and CHIP coverage to legal immigrant children and for low-income pregnant women's prenatal care up to 60 days postpartum (Georgetown University Health Policy Institute, 2015)

Despite these diverse legislative attempts to provide universal healthcare, there were still 49.9 million (16.3% of the total population) uninsured people in the United States as of 2010 (U.S Census Bureau, 2011). The majority of this large uninsured U.S population, known as the gap coverage population, mainly consists of young, childless adults (less than 65 years of age) who typically work at low-paying jobs or jobs without health insurance benefits, cannot afford private health insurance, and do not meet the eligibility requirements for Medicaid (Henry J. Kaiser Family Foundation [KFF], 2015). As a result, the uninsured has accumulated medical bills that they cannot pay which in turn has increased the medical debt and the U.S. healthcare spending up to \$2.6 trillion dollars (approximately \$8,402 per person) as of year 2010 (Henry J. Kaiser Family Foundation [KFF], 2015). Therefore, the healthcare costs in America have outpaced the country's expenditure on other goods and products (Henry J. Kaiser Family Foundation [KFF], 2012). This has hurt the nation's economy and caused state taxes to increase and benefits from businesses and government programs to decrease---leading to less affordable and accessible health insurance and healthcare, and poorer health outcomes (Henry J. Kaiser Family Foundation [KFF], 2012). These factors, combined with the fact that 16 % of the U.S population is estimated to lack health insurance coverage at any point in time (Ridic & Gleason, & Ridic, 2012), have made the United States' healthcare system the most expensive and least effective healthcare system in comparison to other westernized world powers (Davis, Stremikis, Squires, & Schoen, 2014).

Due to the United States' economic and health related frustrations and problems with Americans not having health insurance, President Barack Obama's Patient Protection and Affordable Care Act (ACA) was signed into law in 2010 (The White House, 2015). The main goal of the ACA was to drastically reduce the 16% (49 million) uninsured U.S population, as

reported by the 2010 US census. Since the enactment of ACA, as President Obama stated in his 2015 weekly Address, “So far more than 16 million uninsured Americans have gained coverage. Nearly one in three Americans who was uninsured a few years ago is insured today...The uninsured rate in America is the lowest since we began to keep such records. The law has helped hold the price of health care to its slowest growth in 50 years” (The White House, 2015). This objective was met by expanding affordable medical insurance coverage to those within the gap coverage population who do not receive employer health insurance benefits, are not eligible for Medicaid or Medicare (designated for the poor and elderly), and have an income at or below 133% of the federal poverty limit (Henry J. Kaiser Family Foundation, 2013). However, after five years of political, republican attempts to repeal the law, the permanent existence of the ACA's benefits was not made a reality until June 25, 2015. On this day, the U.S Supreme Court confirmed the ACA's existence with a 6-3 vote ruling in favor of upholding federal tax subsidies for eligible U.S Citizens and legal immigrants residing in states with independent health insurance exchanges or in states with federal exchange marketplaces. (CNN News, 2015) In addition, the ACA also focused on controlling healthcare costs and improving the efficiency of our healthcare delivery system (Henry J. Kaiser Family Foundation, 2013).

Provisions of the Affordable Care Act (ACA) are as follows:

- 1) Unmarried, adult children may remain on their parents' health plan as dependents until the age of 26 years. (Library of Congress, 2015)
- 2) Health Insurance plans are prohibited from excluding individuals and discriminating on the basis of: any preexisting medical conditions, medical and genetic history, history of cancer treatment within clinical trials, any other life-threatening diseases or conditions. Premium rates

are only allowed to vary by individual or family coverage, rating area, age, or tobacco use.

(Library of Congress, 2015)

3) All U.S. citizens and legal residents are required to have qualifying health insurance beginning in 2014---except for those with financial hardship (have incomes below the tax filing threshold and the cost of the lowest plan exceeds 8% of their income), religious objections, American Indians, incarcerated individuals, undocumented immigrants, and those without coverage for less than three months. Fines will be imposed on individuals without health insurance and large employers (employers with more than 50 full-time employees) who fail to offer their full-time employees the minimum essential health insurance coverage or who have a waiting period for enrollment of more than 60 days. (Library of Congress, 2015)

4) The ACA grants states the option to expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of the federal poverty limit (FPL) based on modified adjusted gross income. Undocumented immigrants are not eligible for Medicaid. States who expand Medicaid will receive federal funding for Medicaid in the following phases: 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. (Library of Congress, 2015)

5) The ACA grants states the option to create state-based American Health Benefit Exchanges, also known as the Health Insurance Marketplace (HIM), by 2014 through which individuals can purchase coverage from a diverse number of available private health insurance companies. A federal exchange would be created for use by people living in states that refused to set up their own exchanges. Large employers (greater than 100 workers) are required to pay penalties for

employees who receive tax credits for health insurance through an Exchange. (Library of Congress, 2015) The federal government provides advanced tax credits and cost-sharing subsidies to reduce insurance premiums for individuals and families who have qualifying incomes between 100%-250% of the federal poverty limit according to the following table:

BASED ON U.S. DHHS 2015 POVERTY GUIDELINES

FAMILY SIZE	FAMILY INCOME RANGES									
	To 137.50% of BASE			To 175% of BASE		To 212.50% of BASE		To 250% of BASE		Over 250% of Base
	DISCOUNT 100% Sliding Scale A	DISCOUNT 80% Sliding Scale B		DISCOUNT 60% Sliding Scale C		DISCOUNT 40% Sliding Scale D		DISCOUNT 20% Sliding Scale E		PAY 100% Private Pay
	MAX	MIN	MAX	MIN	MAX	MIN	MAX	MIN	MAX	MIN
1	\$11,770	\$11,771	\$16,184	\$16,185	\$20,598	\$20,599	\$25,011	\$25,012	\$29,425	\$29,426
2	\$15,930	\$15,931	\$21,904	\$21,905	\$27,878	\$27,879	\$33,851	\$33,852	\$39,825	\$39,826
3	\$20,090	\$20,091	\$27,624	\$27,625	\$35,158	\$35,159	\$42,691	\$42,692	\$50,225	\$50,226
4	\$24,250	\$24,251	\$33,344	\$33,345	\$42,438	\$42,439	\$51,531	\$51,532	\$60,625	\$60,626
5	\$28,410	\$28,411	\$39,064	\$39,065	\$49,718	\$49,719	\$60,371	\$60,372	\$71,025	\$71,026
6	\$32,570	\$32,571	\$44,784	\$44,785	\$56,998	\$56,999	\$69,211	\$69,212	\$81,425	\$81,426
7	\$36,730	\$36,731	\$50,504	\$50,505	\$64,278	\$64,279	\$78,051	\$78,052	\$91,825	\$91,826
8	\$40,890	\$40,891	\$56,224	\$56,225	\$71,558	\$71,559	\$86,891	\$86,892	\$102,225	\$102,226

Note: Table 1. Family Income Ranges. Adapted from *Annual Update of the Health and Human Services Poverty Guidelines*, by Federal Register, updated January 22, 2015, Retrieved from <https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines#t-1>

These income-based subsidies, along with Medicaid Expansion, are crucial to the Affordable Care Act's long term success in making health insurance more affordable for the uninsured population.

North Carolina's Reason for Denying Medicaid Expansion

Despite the Federal government bearing 100% of the Medicaid costs for the first 3 years and at least 90% thereafter, North Carolina governor Pat McCrory signed legislation in 2014, rejecting the option to establish a health insurance exchange and rejecting the Affordable Care Act's Medicaid Expansion program (Oberlander & Perreira, 2013).

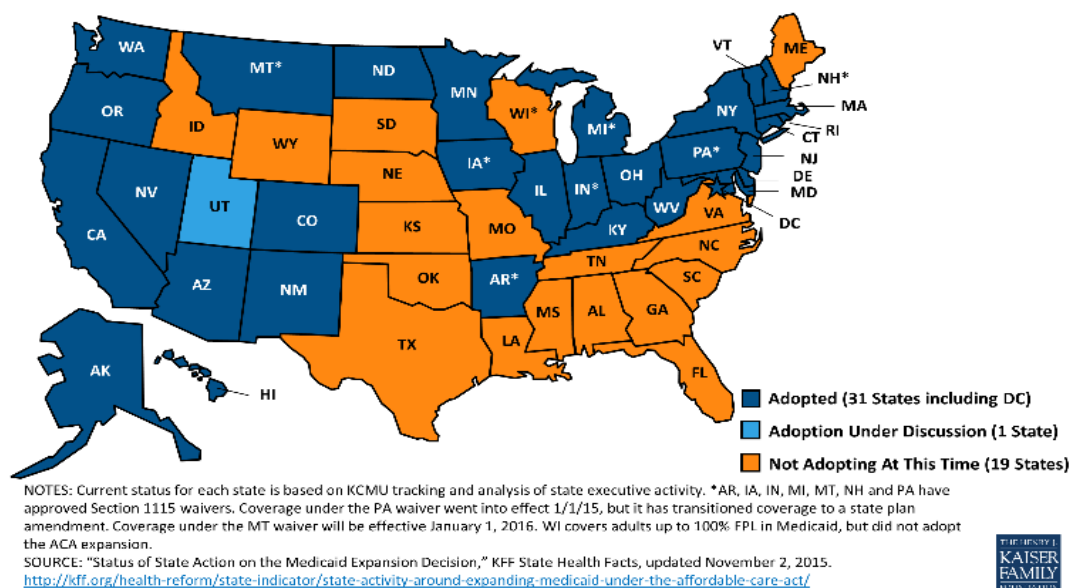
On February 2012, Governor Pat McCrory issued the following statement:

"Throughout our first few weeks in office, we have done a thorough review of the advantages and disadvantages of expanding Medicaid in North Carolina and determining the right exchange option for our state... The results of our findings make it abundantly clear that North Carolina is not ready to expand the Medicaid system and that we should utilize a federal exchange.

Our findings include: 1) In light of recent Medicaid audits, the current system in North Carolina is broken and not ready to expand without great risk to the taxpayers and to the delivery of existing services to those in need. We must first fix and reform the current system. 2) The potential long-term cost to the North Carolina taxpayer and needed flexibility for reform cannot be determined based upon the information and details provided to us by the federal government. 3) There has been a lack of preparation within state government during the past year to build necessary and reliable systems to implement a state exchange. 4) Due to the ongoing political uncertainty of the federal budget deficit, there is long-term concern regarding the federal government's continuing of its obligation for matching funds under the terms of the Medicaid expansion". (North Carolina Governor Pat McCrory, 2013)

As a result of the NC General Assembly's decision, North Carolina remains one of 19 republican states that have rejected Medicaid expansion as of November 2, 2015 (Henry J. Kaiser Family Foundation, 2015):

Current Status of State Medicaid Expansion Decisions



Note: Map 1. Current Status of State Medicaid Expansion Decisions. Reprinted/Adapted from *Status of State Action on the Medicaid Expansion Decision*, by Henry J. Kaiser Family Foundation State Health Facts, updated November 2, 2015, Retrieved from <https://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>

The fact that all of the states that have not expanded Medicaid or refused to set up health insurance marketplaces (HIM) happen to be Republican “Red” states has raised suspicion as to whether there is a partisan Republican agenda to sabotage the success of the Affordable Care Act by any means possible. So therefore Governor Pat McCrory’s explanation begs the following questions: “What are the real reasons why North Carolina rejected Medicaid Expansion? Why would North Carolina refuse to set up its own Health Insurance Marketplace exchange, which would have given the state regulatory control over the Affordable Care Act---a feature that is in accordance with the conservative views? Why would North Carolina jeopardize the lives of millions of poor, working individuals by rejecting billions of dollars in federal healthcare funding needed to promote universal access to healthcare? Since the Governor did not provide any valid scientific data to support or help rationalize his explanation, one would assume that the real reasons are either racist or political. The disturbing inference that the strong opposition to ACA is based on racism was supported by Eric D. Knowles, Brian S. Lowery, and Rebecca L. Schaumberg’s results of their social psychology research study titled, *Racial Prejudice Predicts Opposition to Obama and his Healthcare Reform Plan*. This study assessed the views of those who opposed President Obama’s Affordable Care Act (ACA) and compared them to their views on President Bill Clinton’s former healthcare reform plan, known as the Health Reform Act (HRA). This study found that measures of racial bias were associated more with the strong opposition to President Obama’s ACA plan, but not with the opposition towards President Bill Clinton’s similar HRA plan. The results suggested that prejudiced individuals’ focus on President Obama’s black race overshadowed their ability to see the proven effectiveness and benefits of his ACA policy (Knowles, Lowery, & Schaumberg, 2010). This assumption may be further supported by the 2015 published statistic that adults of color, meaning African Americans

and Hispanics, make up over half (56%) of the total 3.1 million uninsured adults in the coverage gap that would be eligible for Medicaid if it was expanded (Henry J. Kaiser Family Foundation, 2015). Caucasians make up only 42% of the uninsured gap coverage population that would qualify for expanded Medicaid (Henry J. Kaiser Family Foundation, 2015). Furthermore, a large share of the African American population resides in the South, where many states have not adopted the Medicaid expansion (Henry J. Kaiser Family Foundation, 2015). Therefore, uninsured African Americans are more likely to fall into the gap coverage, as a result of denying Medicaid, twice more than Caucasians (Henry J. Kaiser Family Foundation, 2015). These facts suggest that the efforts of republicans to reject Medicaid expansion, at the cost of human lives, may be motivated by racial spite aimed at preventing adult minorities from having health insurance.

In an effort to reject this disturbing, racist theory; one is more inclined to accept the political reason why North Carolina denied Medicaid expansion. Mainly because the Republican majority's repeated arguments do not seem to be in the best interest of the state's residents and yet still remain questionable. First, by Governor Pat McCrory and the Republican majority insisting that Medicaid must first improve before expanding is detrimental to the many lives who are dying as a result of not having health insurance and to those who urgently need it to help control their chronic conditions. Obviously, there are many problems with Medicaid--which may still remain even after accepting Medicaid expansion. However, waiting for perfect conditions before taking a first step to improve a public health issue is not progressive for the state or the country. North Carolina has already proven that when forced to take a step--then the conditions actually improve. Therefore, it is realistic to believe that the Medicaid system could be improved by accepting the ACA's large influx of Federal funding. For instance, North

Carolina refused to implement a state-run Health Insurance Marketplace (HIM)—as suggested by the Affordable Care Act (Henry J. Kaiser Family Foundation, 2013). However, when forced by law to accept the Federal Exchange, North Carolina ranked fifth among the red states with 357,584 people enrolled in a private marketplace insurance plan (U.S Department of Health and Human Services [DHHS], Assistant Secretary for Planning and Evaluation [ASPE], 2014), with a total of 91% of them receiving subsidies as of 2014 (Henry J. Kaiser Family Foundation, 2014). As a result, the uninsured rate in North Carolina decreased from 20.4 percent in 2013 to 16.1 percent in 2014 (Gallop, 2014). This was accomplished by the help of some organizations such as Enroll America. Enroll America is a nonprofit organization, not affiliated with North Carolina's government, that works to enroll residents in states whose government has refused to implement their own health insurance exchanges. (Enroll America, 2015) Hopefully, the state will accept Medicaid expansion in the near future in order to decrease that uninsured rate even further in order to ensure that everyone has equal access to healthcare.

The Consequences of Not Expanding Medicaid in North Carolina

Governor Pat McCrory's argument that "accepting Medicaid will hurt the state's taxpayers and fiscal budget in the future due to the uncertainty of the federal budget and the significant risk that the federal government will not keep its obligation to match funds for Medicaid expansion" (North Carolina Governor Pat McCrory, 2013) is a part of the "bait and switch" argument proposed by the Republican party (Tanner, & Cato, 2012). Bait and switch by the government is defined as leaving the states to pay a greater share of expansion costs in the future once Medicaid Expansion has been accepted (Tanner, & Cato, 2012). A possible rebuttal to this argument is: the state government could have mandated a clause that would allow North Carolina to void their ACA contract and "Un-expand Medicaid" if the Federal Government

ceases to provide federal funding for Medicaid Expansion at any time. Furthermore, states who expand Medicaid will receive federal funding for Medicaid in the following phases: 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years (Library of Congress, 2015). Therefore, accepting Medicaid will incur a very minimal cost to the state's budget.

Regardless of North Carolina's decision to accept or deny Medicaid expansion, the North Carolina Division of Medical Assistance (DMA), estimated that by 2014 approximately 564,000 new people would enroll in Medicaid and CHIP (NC Department of Health and Human Services [NCDHHS], Division of Medical Assistance [DMA], 2014). This increased amount of Medicaid enrollees was expected to increase mainly due to the "Woodwork" group population (Sommers, & Epstein, 2011). The "Woodwork" group refers to those who are newly enrolled into Medicaid and CHIP as a result of applying for private insurance through the Federal or state facilitated Health Exchanges (Sommers, & Epstein, 2011). Since the Federal Exchange and Medicaid are jointly run by the federal and state government, a person who applies for private coverage through the Federal Exchange is also applying for Medicaid and CHIP at the same time (Sommers, & Epstein, 2011). This would have made the total number of people enrolled in Medicaid and CHIP grow to an estimated 624,000 by year 2021 (NCDHHS, DMA, 2014). The U.S Department of Health and Human Services has also reported that 73,898 North Carolinians, from October 1, 2013 to March 31, 2014, had been determined eligible for Medicaid and CHIP programs by the Federal exchange (U.S Department of Health and Human Services [USDHHS], Assistant Secretary for Planning and Evaluation [ASPE], 2014). This means that the

"woodwork" enrollees will likely cost the state more money overtime if the General Assembly continues to deny Medicaid expansion instead of accepting it (Sommers, & Epstein, 2011).

Moreover, in 2012, North Carolina Governor Beverly Perdue's administration contracted the Regional Economic Model, INC (REMI) to conduct a state-level economic analysis. This analysis simulated the economic impact of Medicaid Expansion on the state if it elected to provide coverage for individuals with incomes up to 138% of the federal poverty level. REMI is an independent private company that developed an economic computer software tool used by state governments nationwide in order to understand the economic impact of public policy decisions (Regional Economic Models, Inc. [REMI], 2013). A REMI data analysis from 2014 to 2021, showed that Medicaid expansion could potentially be a positive for North Carolina and its economy (REMI, 2013). According to REMI, the new federal funds from the Medicaid expansion would generate approximately 25,000 jobs by 2016 (REMI, 2013). REMI estimated that North Carolina's state taxes would increase from approximately \$17.2 million in 2014 to \$60.7 million in 2021 (REMI, 2013). However, due to the high federal match rate that offsets the new tax revenue, NC would experience a net savings of 65.4 million from the Medicaid expansion from 2014 to 2021 (REMI, 2013). Also, the REMI analysis estimated that there would be a net increase of jobs mostly related to healthcare and research (REMI, 2014). This job growth is estimated to increase from 5742 in 2014 to 23,211 in 2017 and to about 18,000 sustained jobs by 2021 (REMI, 2013). According to REMI, the state's net annual expenditure will be approximately \$118.7 million by 2021 (REMI, 2013).

In 2013, the Cone Health Foundation contracted the Milken Institute School of Public Health at George Washington University, which received technical assistance from REMI, to conduct a county level analysis assimilating the economic effects of closing the Medicaid coverage gap (Ku, Bruen, Steinmetz, & Bysshe, 2014). This analysis denoted that Medicaid Expansion

would increase county tax revenues without changing tax rates because the counties would only have to pay for administrative fees for the expansion (Ku, Bruen, Steinmetz, & Bysshe, 2014). Since Medicaid was not expanded from at the beginning of 2014, the data table below, using a few counties as an example, illustrates the fact that North Carolina counties have lost jobs leading to lower employment, less economic activity, and lower tax revenues in 2014 through 2015 (Ku, Bruen, Steinmetz, & Bysshe, 2014).

Table 2. Examples of Economic and Employment Losses in Selected North Carolina Counties Because Medicaid Was Not Expanded in 2014 (Compared to Levels If Medicaid Expanded)			
County	Category	2014	2015
Buncombe	Total Jobs Not Created	807	1,004
	Gross County Product Lost (mil \$)	\$60	\$75
	County Business Activity Lost (mil \$)	\$92	\$115
	County Tax Revenue Lost (thou \$)	\$575	\$775
Guilford	Total Jobs Not Created	1,762	2,156
	Gross County Product Lost (mil \$)	\$156	\$193
	County Business Activity Lost (mil \$)	\$252	\$310
	County Tax Revenue Lost (thou \$)	\$1,255	\$1,665
Mecklenburg	Total Jobs Not Created	2,592	3,155
	Gross County Product Lost (mil \$)	\$236	\$294
	County Business Activity Lost (mil \$)	\$372	\$461
	County Tax Revenue Lost (thou \$)	\$2,262	\$2,905
Pitt	Total Jobs Not Created	822	401
	Gross County Product Lost (mil \$)	\$25	\$31
	County Business Activity Lost (mil \$)	\$40	\$50
	County Tax Revenue Lost (thou \$)	\$272	\$378
Wake	Total Jobs Not Created	2,508	3,199
	Gross County Product Lost (mil \$)	\$232	\$302
	County Business Activity Lost (mil \$)	\$364	\$469
	County Tax Revenue Lost (thou \$)	\$2,677	\$3,636
All other counties	Total Jobs Not Created	15,527	19,199
	Gross County Product Lost (mil \$)	\$983	\$1,221
	County Business Activity Lost (mil \$)	\$1,564	\$1,935
	County Tax Revenue Lost (thou \$)	\$10,100	\$13,686
All dollars are in constant 2014 dollars. County tax revenues are in thousands of dollars. For example, the level of "\$1,255 thousand" in Guilford County is the same as "\$1.255 million".			

Note: Table 2. Examples of Economic and Employment Losses in Selected North Carolina Counties Because Medicaid was Not Expanded in 2014 (Compared to Levels if Medicaid Expanded). Reprinted/Adapted from *The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis*, p. 10, by Ku, L., Bruen, B., Steinmetz, E., & Bysshe, M. T., 2014, Retrieved from <https://www.conehealth.com/app/files/public/4202/The-Economic-and-Employment-Costs-of-Not-Expanding-Medicaid-in-North-Carolina.pdf>

According to Table 2 above, there were approximately 1762 fewer jobs in Guilford County, Wake county lost \$2.7 million in potential county tax revenues, and Buncombe County had \$92 million less

in business activity in 2014. If North Carolina continues to deny Medicaid Expansion, this economic simulation estimated that reductions in job growth will continue to effect all North Carolina counties--with the largest economic reductions occurring in the largest counties from 2016 to 2020 (Ku, Bruen, Steinmetz, & Bysshe, 2014). For instance, Durham County alone is estimated to have over 5,000 fewer jobs created in 2020 if Medicaid is not expanded (Ku, Bruen, Steinmetz, & Bysshe, 2014).

In addition, approximately \$161 million in county tax revenue plus \$860 million in state revenue would potentially be lost from 2016 to 2020 (Ku, Bruen, Steinmetz, & Bysshe, 2014). This made the state's total economy decrease by about \$1 billion dollars from 2016 to 2020 as a result of refusing to accept Medicaid Expansion (Ku, Bruen, Steinmetz, & Bysshe, 2014). Based on these findings, it is evident that the decisions made by Governor Pat McCrory's Administration has caused North Carolina to lose a serious amount of financial opportunities needed to stimulate the economy and create jobs across the state of North Carolina (Ku, Bruen, Steinmetz, & Bysshe, 2014).

Numerous studies show that Medicaid has helped improve access to affordable, timely, preventive healthcare---which has decreased the mortality rate among many states that have expanded Medicaid (Sommers, Baicker, Epstein, 2012). A randomized study on the state of Oregon, an expanded state, found that people with Medicaid were 40 percent more likely to use preventive care services and less likely to suffer a decline in health as a result (Sommers, Baicker, Epstein, 2012). Currently, North Carolina's Medicaid system provides coverage to the disabled, pregnant women, children, and to parents with incomes up to 45% of the federal poverty level (Centers for Medicare and Medicaid Services, 2014). These strict eligibility requirements, in addition to the state's refusal to expand Medicaid, have created an uninsured, gap population of 463,000 lower-income individuals in North Carolina (Henry J. Kaiser Family

Foundation, 2015). Currently, 244,000 out of the 463,000 gap coverage population would be eligible for Medicaid if the state had opted for expansion (Henry J. Kaiser Family Foundation, 2015).

The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) prohibits Emergency Departments from refusing treatment to individuals regardless of legal status, or ability to pay (Centers for Medicare and Medicaid Services [CMS], Emergency Medical Treatment and Labor Act [EMTLA], 2015). Therefore, North Carolina's uninsured, gap coverage population is more likely to visit the emergency room for healthcare due to having no other place to go (Gindi, Cohen, & Kirzinger, 2012). Also, this uninsured gap population typically receives uncompensated care when sick and burden the state's hospitals with unsustainable healthcare costs (Manning, 2014). As a result, the following three rural hospitals were unable to withstand the financial stress and have closed: Yadkin Valley Community Hospital, and Blowing Rock Hospital, and Vidant Pungo Hospital (UNC Cecil G. Sheps Center for Health Services Research, 2015). This decrease in accessible healthcare resources, compounded with the loss of federal funding, caused North Carolina to be currently ranked at 37th in health performance among the 50 states and the District of Columbia (United Health Foundation, 2014).

However, this low health performance rating could be improved if North Carolina focused on using Medicaid Expansion as an intervention tool for achieving its Healthy North Carolina 2020 Objectives. Healthy North Carolina 2020 Objectives are a set of goals, outlined by the N.C. Department of Health and Human Services (NCDHHS), that address the state's high priority public health issues. The current Healthy North Carolina 2020 objectives are aimed at decreasing the prevalence and mortality rates associated with chronic diseases such as:

cardiovascular disease and diabetes. (N.C Department of Health and Human Services [NCDHHS], North Carolina Public Health [NCPH], 2015) Medicaid provides access to disease management and coordination of services for people with these chronic conditions (Sommers, Baicker, Epstein, 2012). This benefit is illustrated by associating the current Healthy North Carolina 2020 Objectives each with an advantage of Medicaid coverage, as outlined below:

Healthy North Carolina 2020 Objective 1: Reduce the cardiovascular disease mortality rate (per 100,000 population) from baseline 256.6 (2008) to 161.5 by 2020 (NCDHHS, NCPH, 2015). In 2010, cardiovascular disease was the leading cause of hospitalization, discharge, and readmission rate in North Carolina (NCDHHS, NCPH, 2015). This put a great financial burden on the state's economy of \$5.5 billion dollars (NCDHHS, NCPH, 2015). In 2012, North Carolina had 4,382 older adults (age 65 and older) die from a stroke (NCDHHS, NCPH, 2014). This accounts for North Carolina's age-adjusted stroke death rate being ranked 10th in the nation (NCDHHS, NCPH, 2014).

Medicaid Advantage for Objective 1: Medicaid provides coverage for disease management and coordination of services for 80% of uninsured people living with uncontrolled high blood pressure or cholesterol helps to control the risk factors for disability-related stroke (Henry J. Kaiser Family Foundation, 2012).

Healthy North Carolina 2020 Objective 2: Decrease the percentage of adults with diabetes from baseline 9.6% (2009) to 8.6% by 2020 (NCDHHS, NCPH, 2015). Diabetes is considered an epidemic in North Carolina and is now the seventh-leading cause of death in North Carolina. Diabetes is estimated to cost the state more than \$17 billion per year in medical expenses and lost productivity by 2025. (Center for Health Law and Policy Innovation, 2014).

Medicaid Advantage for Objective 2: Medicaid adults with diabetes are more likely than low-income uninsured adults with this illness to have more access to critical health care services with lower out-of-pocket costs. Nearly all diabetics with Medicaid coverage (97%) reported that they had consistent healthcare, versus the over 20 percent of uninsured adults with diabetes who reported that they had not had a check-up in the past two years---a finding that is remarkable given the amount of care needed to control diabetes. (Henry J. Kaiser Family Foundation, 2012)

These are all challenging objectives that healthcare professionals and individuals all over North Carolina are working hard to achieve in order to improve the rate of positive health outcomes related to cardiovascular disease and diabetes. Therefore, it is evident that expanding Medicaid coverage is an urgent intervention needed to achieve these objectives and to decrease the morbidity, mortality rate, and excessive healthcare spending associated with chronic conditions.

Purpose

The overall goal of this qualitative research study is to explore and explain North Carolina General Assembly's reasons for denying the Affordable Care Act's Medicaid expansion and its constituents' response to this decision. This investigative study project attempts to answer the following questions: 1) Why does North Carolina need to accept the Affordable Care Act's (ACA) Medicaid Expansion? 2) How did the state's decision to deny Medicaid expansion impact the healthcare management of its uninsured adult population?

Method

Subjects

Participants consisted of men and women of at least 21 years of age and of all ethnicities. These participants had some basic knowledge of North Carolina's Medicaid and healthcare management system prior to participation in the study—however this was not an inclusion criteria for the study. Participants only had to be at least 21 years of age and there were no exclusion criteria based on race, gender, or ethnicity involved in this study. A convenience sample of 10 residents from the tri-county (Wake, Durham, Orange) and Edgecombe, Nash, Wilson, Green, Pitt, and Wayne rural counties participated in the study. The sample included:

(2) N.C House of Representatives from the N.C General Assembly

(1) Mental Health Social Worker

(2) Affordable Care Act Navigators

(1) Enroll America Deputy Regional Director

(1) Case Manager

(1) Business Owner and Geriatric Case Manager

(1) Professor of Health Policy and Administration

(1) Associate Dean for Research at a School of Nursing

Instrument

Participants were asked to complete an audio-recorded interview, regarding the study, via a recruitment announcement (see Appendix B) emailed to their publically identified email addresses. Participants' consent to be interviewed was obtained through a consent form created by the principal investigator (See Appendix A). Both the consent form and email recruitment announcement were created by the principal investigator. The consent form only asked for

signature and phone number and did not ask the participants for any self identifiers such as age, date of birth, occupation, location of employment. A Sony digital voice recorder was used to record the interviews and collect informant data given through the dialogue between the investigator and the participants.

Given the traditional low response rate for data surveys, the investigator developed a 12 open-ended question survey (see Appendix C) to collect informant data from the interviews. This style of surveying was needed in order to collect the most accurate, informative data that represented the health care management, attitudes, and perceptions of North Carolinians regarding the General Assembly's decision to deny Medicaid. These specific survey questions addressed the impact of North Carolina's decision to deny Medicaid expansion on its healthcare and economy. Particular emphasis was put on gathering responses related to how refusing to expand Medicaid affected the North Carolinians within the gap between private and Medicaid health insurance coverage. Questions were rephrased in order to enhance the informant's understanding of the questions. Additional exploratory questions were asked in order to gain more information from the participants' responses. The principal investigator transcribed the voice recorded audios. Hardcopies of the transcripts and a literature review (using sources less than 5 years old) were analyzed and conceptualized for relevant qualitative data.

Procedures

The approval process for conducting this study involved a screening process from the Institutional Review Board (IRB) at UNC Chapel Hill. The study received final IRB approval with exemption and a no conflict status (IRBIS 15-2162) on September 29, 2015. The study was not initiated until IRB approval was received. After receiving IRB approval, potential participants' email addresses were identified through public directories. The investigator then

recruited these participants by emailing them encrypted emails that contained the email recruitment announcements and consent form through the website: <https://outlook.unc.edu>. Obtaining consent through these encrypted emails was one of the main barriers to collecting informant, qualitative information. Many of the potential participants expressed frustration that they could not open the encrypted emails or some of them could not receive them at all. There were two respondents who did not agree to be interviewed by not responding to the email recruitment announcement. Perhaps this may be attributed to the encrypted emails, their reluctance to get involved in controversial political topics, or due to their lack of interest about the subject matter. Thirteen potential participants were contacted and 11 out of 13 responded and showed interest in the study. However, due to the technicalities of the IRB requirements and time constraints, only ten people were consented and interviewed for the study. Each participant returned their signed consent forms back via email to the principal investigator's return email address. Once the signed consent forms were returned to the investigator, then the forms and participants were assigned a 5 digit numerical code. This prevented the informant data from being traced back to the individual subjects. The signed consent forms were stored in an external hard drive at an undisclosed area that was only known by the investigator. Only two participants were not recruited through the encrypted emails. These two participants wanted to be interviewed the same day that they were informed of the study within their community. Therefore, they were explained about the purpose of the study, consented in person, and given a copy of the email recruitment announcement and their signed consent form the same day of the interview.

Each participant given a verbal explanation of the purpose of the study and was allowed to choose their own location for the interview in order to protect their privacy. Some of the

participants elected to do an over the phone interview in order to protect their privacy. At the beginning of each interview, all participants were informed that the interviews are recorded, their anonymity will be maintained throughout the study, their participation is voluntary, they could refuse to answer any question without penalty and that they could stop the interview at any time. During the interviews, each participant was asked to respond to the 12 open-ended question survey (please see Appendix C) related to NC Medicaid, the Affordable Care Act, and the gap coverage population. Most of the participants were asked all 12 open-ended questions. However, certain questions were not asked if it was assumed that they were not in accordance with the participant's knowledge of expertise.

All audio recordings of the interviews were transcribed by the principal investigator. Participants' occupational location, race, and age were not included in the transcription and/or the publication of the data. Without exception, all subjects, audio recordings, and transcripts were kept anonymous, private, and secure by the investigator throughout the research study and thereafter. The information obtained from the literature review and the transcribed interviews was integrated and conceptualized in order to gain insight into how North Carolina's denial of Medicaid expansion has impacted the healthcare management of North Carolina's uninsured adult population.

Results

The informant data, in the form of free responses from the participants' interviews, were integrated and conceptualized for common themes and perceptions. The data also provided cases exemplifying how N.C.'s political decision to deny Medicaid expansion has effected the healthcare management and the amount of resources available to the uninsured gap population. Scrutiny of the data resulted in the following emerging themes and perceptions:

Theme A-Majority of the Community are in Favor of Expanding Medicaid and Believe that there was a Political Reason for Denying It:

Nine out of ten participants stated that they are in favor of expanding Medicaid. One out of 10 participants remained neutral; refused to give an opinion or stance on Medicaid Expansion; and refused to state what she believed to be the reason for denying it (Anonymous#53801, personal communication, October 16, 2015). Two out of the nine participants that approved of Medicaid Expansion did not know the reason for denying Medicaid Expansion. Seven out of the nine participants who approved of Medicaid Expansion believed that Governor Pat McCrory and the Republican majority's refusal to expand Medicaid was based on politics. Some of the comments from the nine approval participants who were in favor of expanding Medicaid are as follows:

1) A professor of public health policy stated, "It's just the states that are red states want to keep Government out as much as possible, want to keep taxes low, especially for the rich and corporations and so it's politics driving it. Just like Medicare, I don't know if you knew that Medicare had a Part A and Part B....Part C and a D. C is the Part A, B,C, and D.... That's why we have Medicare that's broken up into pieces because it was a political compromise (Anonymous #53809, personal communication, November 7, 2015)".

2) One Affordable Care Act navigator stated, "Of course they didn't really want the Affordable Care Act to get off the ground....And, then, you know, I think it was the Republicans way of saying, you know what? Since it did, since the Affordable Care Act is in process, and it is happening now, we can do, what we CAN do, and say, well, we're not going to expand Medicaid (Anonymous#53802, personal communication, October 21, 2015)".

3) A N.C. House of Representative stated, "It's, it's really, it's horrible. And it should be criminal. You know, we are making policies decision that result in other people's deaths and we should not be allowed to do that....The people who are currently in control right now do not believe in government delivery of human services. They are, they would privatize education. They would give the tax payer dollars to the private sector to run everything and they don't, they don't believe in delivery of health and human services. They believe people ought to take care of themselves. And they don't like, they don't like the current president. They are part of the "let's do anything to make our current president fail". Regardless of the impact it has on human beings. On their citizens. On their constituents. On their own constituents. Probably on their own family members (Anonymous#53810, personal communication, November 7, 2015)".

Theme B-North Carolina's Decision to Deny Medicaid Expansion Caused Adverse Economical and Public Health Effects for North Carolinians and the State

Eight out of ten participants perceived that N.C. General Assembly's decision to deny has had detrimental effects on the state's economy; and has prevented a lot of people from getting health insurance and gaining access to healthcare services. Two out of ten participants did not feel knowledgeable enough to comment on how the decision has impacted the state and North Carolinians. A N.C. House of Representative said that not expanding Medicaid has prevented people from getting mental health services resulting in more people being sent to jails and prisons (Anonymous#53810, personal communication, November 7, 2015). An Affordable Care Act (ACA) Navigator stated that he has had to turn a lot of people away from getting insured through the Affordable Care Act's Federal Exchange because their adjusted gross income fell below the required 100% Federal Poverty Level (\$11,770 for a single individual) (Anonymous#53802, personal communication, October 21, 2015). He said that even those who

were \$1.00 under the income requirement (\$11,770) were not allowed to sign up for insurance through the exchange (Anonymous#53802, personal communication, October 21, 2015). He said that if the state would have expanded Medicaid then they would have been able to get some form of insurance (Anonymous#53802, personal communication, October 21, 2015).

One N.C. House of Representative stated that up to 500,000 people have been denied healthcare, resulting in sending more people to the emergency room for treatment, and about 1800-2000 deaths (Anonymous#53810, personal communication, November 7, 2015). Another N.C. House of Representative stated that the biggest problem with the state's decision was that it resulted in a loss of revenue and jobs for the state (Anonymous#53803, personal communication, October 28, 2015). This representative stated, "We were very disappointed because we know that, the lack of expansion, of the Affordable Care Act created a situation where North Carolina lost out on 2.7 billion dollars in Federal funding in 2014 and it's losing 3.3 billion in 2015 compared to the amount it would have earned had it expanded Medicaid in 2014. As a result of not expanding, there was more than 23,000 fewer jobs, being created in the state in 2014 and an additional 29,000 fewer jobs in 2015 (Anonymous#53803, personal communication, October 28, 2015)".

Theme C-There is a Serious Lack of Knowledge about how NC's Decision has Adversely Affected North Carolina's Case Management System of the Uninsured Gap Coverage

Population:

Nine out of ten participants did not have any knowledge of how the decision to deny Medicaid Expansion affected the case management of the uninsured gap coverage population. One N.C. House of Representative stated, "I think that we had a press conference in the last year or two where we had some of those people come in, but when I need to find somebody that falls into that category, I depend on the Health Access Coalition. They or some other groups that are

in touch with that population. I haven't had anybody call me directly. None of my constituents have called me to talk about that (Anonymous#53810, personal communication, November 7, 2015)". Only 1 out of 10 participants could specifically describe how denying Medicaid expansion has adversely affected the case management of North Carolina's uninsured gap coverage population---particularly the mentally ill (Anonymous#53805, personal communication, November 5, 2015). This participant stated, "The majority of the mentally ill population are young, like in their 20's and 30's, but cannot work because of their mental health disability. They suffer from severe mental illness like depression, Schizophrenia, Bipolar and those that really disable them from functioning, taking care of themselves, find a job and work. Most of the patients are unemployed and they have no income, no resources. They tried to apply for disability but got denied. They can't apply for income or food stamps from the Department of Social Services because they don't have children....They can't really access any kind of resources. If they need enhanced services such as case management, therapy, and close monitoring in a community, they can't access that service unless they have Medicaid...We work with the Alliance through the Durham County, Wake County, they will be put on the wait list but that list can extend to 2 years. So a lot of times the mentally ill patients come to us in crisis because they cannot access services out in the community.... A lot of time people without insurance or without Medicaid will be pretty much pushed way back at the bottom to receive care. Even though we try to link them in a community, they are not able to access it unless they are re-hospitalized multiple times (like 10 times) and then they start to flag them and start to think about something different that they can do for them. So unless that happens, then the patient is just being referred and then we don't ever hear from them again. So then we don't know

even if they really received the care

(Anonymous#53805, personal communication, November 5, 2015)".

Theme D- The Uninsured Gap Coverage Population has Access to Limited Healthcare

Resources:

Nine out of ten participants stated that people who did not qualify for ACA private insurance or Medicaid often went to: emergency rooms, charity, public hospitals, and health centers that provide healthcare on a sliding scale or at a discounted rate for care. However, one out of ten participants stated that they did not know of any specific resources available to the uninsured gap population (Anonymous#53806, personal communication, November 6, 2015). One N.C. House of Representative stated," No, no, they just out of luck. And the only thing that they can count on is charitable services from agencies like we call partisan health or volunteer medicine which we have in Louisburg. It's a free clinic. And they have fundraisers and they have people making donations so that someone who is under-insured or uninsured can access at least some services, some amount of healthcare services, But there are no exceptions to North Carolina policies at all (Anonymous#53803, personal communication, October 28, 2015)". A specific list of the following healthcare resources was mentioned among the remaining nine participants:

- Lincoln Community Health Center in Durham, NC—affiliated with Duke and Durham Regional. This center provides medical services on a sliding scale and at a discounted rate.
- UNC Charity Care
- Cancer Prevention Treatment Act: People who qualify with incomes at 250% of the FPL can get treatment for breast and cervical cancer.

- Piedmont Health Center
- Alliance Behavioral Healthcare: provides mental health mobile crisis services in Durham, Wake, Cumberland and Johnston counties to those experiencing a mental health or chemical dependency crisis.
- Community Care Network of North Carolina: Home Health agency aimed at preventing hospital readmissions by monitoring and assisting people in their homes who have recently been discharged from the hospital.
- Project Access in Durham, NC: provides assistance for physician visits and prescriptions.

A N.C. House of Representative commented about the use of these charitable organizations and said, “But the thing that people fail to understand is that charitable services causes your policy and my policy to be more costly, because the insurance companies are going to get their payment from somewhere. So, to cover some of the people that are not able to pay, we end up increasing the policy- the premium on people who can pay. So, Blue Cross and Blue Shield has called for the governor to expand Medicaid but he has not (Anonymous#53803, personal communication, October 28, 2015)”.

Theme E-The Majority Believe that Refusing to Expand Medicaid has Adversely Affected Rural Healthcare:

Seven out of ten participants stated that they believed that the denial of Medicaid expansion was a contributing factor leading to the closing of rural hospitals and a decrease in the amount of available free clinics within the rural counties. This drastically decreased the amount of accessible healthcare resources available to rural county residents. Three out of ten participants stated that they did not know enough information to perceive how rejecting Medicaid Expansion has affected rural healthcare. A N.C. House of Representative stated, “if

the state would have expanded Medicaid then the hospitals would not have closed because it would have had additional revenues coming from the Federal government....The rural hospitals that have recently closed in three areas are: Louisburg (Franklin County), Belhaven, and Yancey County, which has created a burden on the local government....as a result the emergency care is running cross-county, several different ways, which is putting more pressure on health departments that try to serve people that were normally getting their services from the hospital (Anonymous#53803, personal communication, October 28, 2015)". A mental health social worker stated that there was also a serious lack of healthcare resources available for the mentally ill, as a result of refusing to expand Medicaid (Anonymous#53805, personal communication, November 5, 2015). She stated that her hospital organization sees an influx of people coming through their emergency room trying to seek care because they have nowhere else to go (Anonymous#53805, personal communication, November 5, 2015).

Theme F-Chronic Conditions and Mental Illness Account for the Majority of Personal Accounts Illustrating the Ill Effects of Denying Medicaid Expansion:

Seven out of ten participants gave personal accounts of people who they knew were part of the gap coverage population and were denied both ACA private insurance and Medicaid. Two out of ten participants did not know of any personal cases related to how the state's denial of Medicaid Expansion personally affected the uninsured gap coverage population. In error, one out of ten participants was not asked to recall a personal case of someone who was adversely affected by the state's denial of Medicaid Expansion. Five out of ten participants described cases related to surgical needs and chronic diseases such as, diabetes, undiagnosed progressive tremor, cancer, and mental health---causing emotional distress. Two out of ten participants described

personal cases, but did not specify the type of illnesses of the unknown people. Two examples of personal accounts are as follows:

1) Cancer Case: A public health policy professor stated, "...my sister died probably 4 years ago. She and her husband were artists and uninsured so she went to a center to get a mammogram when she thought she had a lump and it was not a center that was covered under the Breast and Cervical Cancer Prevention Treatment Act ... but the center that she went to didn't tell her to go to the right place so she didn't qualify for care so she died. ... so they were contributing people with graduate degrees but because they didn't have high incomes my sister had to die but yet idiots who work in banks and investment banking and basically rape and pillage the world, they have health insurance but people that are, you know, farm workers and people that are self-employed can't get health insurance. It's a really bad situation. . In fact, she did get a mastectomy but not follow up care and I refinanced my house so that I could help her pay the \$16,000 for her mastectomy (Anonymous#53809, personal communication, November 7, 2015)".

2) Mental Health Case: A mental health social worker stated, "...one of the patients that I had, she came in and out of the hospital pretty much every month. You know, so did, so she came to the Emergency Room, I think 8-9 times. And then we started to say "Wait a minute." You know. "We really need to do something different." So we really worked with an Alliance to identify, you know what else can we do differently to make sure that she has access to the outside care. So I think it's, it's very hard, you know, trying to get people hooked up to resource because we have to really advocate for them so (Anonymous#53805, personal communication, November 5, 2015)".

Theme G-There are no known State Government Level Changes in Health Policy or Current Alternative Insurance Plans Given to Accommodate the Gap Coverage Population in lieu of Expanding Medicaid:

Eight out of ten participants reported that they did not know of any current state level alternative insurance plans and changes in public health policy made to accommodate people who have been denied health insurance as a result of not expanding Medicaid. Two out of ten participants stated that there have been changes to Medicaid made in the past and plans to make more changes in the future---but no policy or health insurance changes have been made specifically aimed at accommodating the gap coverage population. A professor of Health Policy and Administration stated, "changes have only been made of what is already the basics of

Medicaid...They made provisions in order to allow more people within those guidelines to possibly be eligible (Anonymous#53809, personal communication, November 7, 2015)".

A N.C. House of Representative reported that the state government is planning to reform Medicaid instead of providing alternative insurance plans (Anonymous#53810, personal communication, November 7, 2015). She stated, "...the N.C government is considering moving from a fee for service to a bundled system and contracting and turning the management of Medicaid; taking it away from the department; and giving it to either managed care organizations or provider led entities, which would be a channel of care organizations that are run by providers groups....So, the manage, I don't know that there's a whole lot of difference between managed care companies and provider led entities, but acceptance in managed care companies have are more driven by profits, they are more likely to be out of state. Their care management is more likely to be by telephone, maybe even from another country. The provider, the entities will be people who are in state, the money will stay in state, there's no shareholder, well, there may be shareholders, especially with some hospitals, but it will be led by providers who have more of a service orientation rather than a profit motive, and the care management will be more on-hand..." "And so, that has nothing to do with expanding. It actually will not improve our Medicaid system in North Carolina. We have a very, we have a very, well-rounded Medicaid system. The problems with our, our Medicaid systems are administrative. We don't have the expertise that we need at the state level, at the, in, in the department, in the division of medical assistance. It is a very complex system. You really need to hire somebody who knows what they are doing and we have had a serious, I mean, I have been in general assembly for nineteen years and I believe we've had fifteen or sixteen Medicaid directors. They don't stay very long (Anonymous#53810, personal communication, November 7, 2015)".

Theme H-Majority Believe the State Can Accept Medicaid Expansion and Still Control Costs:

Seven out of ten participants stated that they believe that the state could accept Medicaid Expansion and still control the costs of Medicaid spending. Only three of the participants did not know or were unsure about how the state could control Medicaid costs. Seven out of ten participants proposed some of the following strategies for controlling Medicaid costs:

- Link the uninsured with the appropriate affordable primary care systems so that they can access preventive care so that their chronic illnesses can be better managed and controlled. As a result, people stay out of the emergency departments and the societal costs of medical care are lowered.
- Increase taxes.
- Do a screening process in order to make sure that the spending is appropriate for those who need it.
- Provide more Medicaid healthcare providers so that the help is there for those who need the service so that they don't remain in the gap of medical coverage.
- Accept the ACA Federal monies given to states that accept Medicaid Expansion.

Theme I-Majority Believe That N.C Could Make Changes, Other than Expanding Medicaid, in Order to Ensure that Everyone Has Fair Access to Health Insurance:

Six out of ten participants proposed alternative ideas to Medicaid Expansion: First idea is to elect Republicans out of office and vote in Democrats. NC should also implement its own state-run Health Insurance Marketplace, which will give North Carolinians a larger variety of insurance companies to choose from. One ACA Navigator stated, "Right now there are only three insurance companies in the Federal exchange set up for N.C. which are: Blue Cross Blue Shield, United Healthcare, and Coventry....and there are so many health insurance

companies out here that I think eventually will be a part of the Affordable Care Act, but we need them now (Anonymous#53802, personal communication, October 21, 2015)". The state also needs to provide more healthcare resources and housing for the mentally ill. A mental health social worker stated, "That's another big issue for people with mental illness. That they're homeless. So, and you know, it's just like a cycle. So, if they can increase, you know, in the housing somehow agency services, and also open up access to mental health care in a community rather than just like a patchwork. Because like I said, a lot of times people will just go to Emergency Room, you know because they in crisis, you know as an inpatient, and you know we have to keep them sometimes for a month. Sometimes, people will stay with us up on our unit for like 2 or 3 months because of the housing issue and because they have nowhere to go or because they have no access to outside, you know inter-community care. And so, it's really difficult in, you know in that. So I think, you know if there's some improvement in that area, I think that would be a tremendous help (Anonymous#53805, personal communication, November 5, 2015)". The state should also make the health insurance plans affordable, for people other than the poor, by decreasing the deductibles, decreasing the required copays, and put a cap on the monthly insurance premiums so that they don't keep increasing. One self-employed business owner stated that she has two kids in their twenties on her policy and right now she is paying over \$1100 per month and every year the monthly premiums have increased (Anonymous#53804, personal communication, November 5, 2015). The government needs to provide a larger supply of primary health care providers in order to keep the healthcare costs down. A Professor of Public Health Policy suggested that the state needs to create more clinics designed to take care of the poor that are managed by healthcare nursing students, Medical students, and Nurse Practitioner faculty who need clinical hours in order to keep their licenses

current (Anonymous#53809, personal communication, November 7, 2015). Last, provide more media coverage in North Carolina that advertise about ACA open enrollment and how to register for an ACA private insurance plan. An Enroll America Deputy Regional Director stated, “Well the website was a little rocky at first, which that didn't help. And actually the research shows that a lot of people have gone to the website and tried to figure it out, but didn't complete it because they got confused. That's, that's good news that people are looking, but it's bad news because they don't understand. They didn't know that you could call somebody to make an appointment for free. There's navigators again that I mentioned, those are vital to the process. And so there's navigators in every county that could be meeting with people that are available to sit down and walk you through the process. And we know that people, that the research also shows that when you do sit down with a navigator, you're more likely to enroll because they're there to help you understand the process. All those people who went to the website and couldn't figure it out and just you know kind of gave up, who knows, they could have enrolled if they had all the information (Anonymous#53801, personal communication, October 16, 2015)”.

Only four out of ten participants stated that they did not know what North Carolina could do, other than expanding Medicaid, in order to close the gap between Medicaid and Private insurance coverage.

Discussion

This study denoted that there is a high interest within the Tri-county (Wake, Durham, Orange) and rural county areas about this political, public health topic. Thirteen potential participants were contacted and 11 out of 13 agreed to conduct an interview on the subject. However, due to the technicalities of the IRB requirements and time constraints, only ten people were interviewed for the study. One may propose that more advertisement within North

Carolina on the Affordable Care Act Enrollment, continued education, and more focused training be done within the community to ensure that everyone understands the benefits of the Affordable Care Act and Medicaid Expansion. Regardless of the participants' background of knowledge or work experience, most of the participants (8 out of 10) gave some insightful information that helped enhance the understanding of the healthcare management of the uninsured gap coverage population. The participants' level of detailed responses was not correlated to their social status or educational level. The level of detail was more dependent on the participants' amount of experience with the target gap coverage population, experience with health insurance policy, and their exposure to current political affairs. For instance, the ACA navigators were able to give more detailed responses about the technicalities of applying for insurance through the Federal Exchange Marketplace; as opposed to college professors who were able to give more information about public health policy. However, the equalizer among the different levels of experience was the fact that 70% (n=7) of the participants were able to describe in detail a case about someone they knew who was adversely affected by being in the insurance coverage gap as a result of North Carolina's denial of Medicaid expansion. These cases indirectly gave good insight into how the gap coverage population's health was being personally affected.

During the interviews, participants were given the opportunity to add additional comments and describe personal cases regarding the uninsured gap coverage population. However, this research study did not specifically tell much about the attitudes and perceptions directly from the uninsured gap population. Therefore, a larger and more diverse pool of participants is needed in order to correlate the responses to the perceptions representative of the current North Carolina population.

The literature review indicated that Medicaid expansion is the key to promoting the well-being of North Carolina's public health and economic systems. Increased enrollment in Medicaid provides more access to preventive care leading to a decrease in the morbidity and mortality rate of chronic diseases such as: cancer, heart disease, stroke, chronic lung disease and unintentional injuries (NC Department of Health and Human Services [NCDHHS], 2015). As previously mentioned, the acceptance of Medicaid Expansion will bring more Federal money into North Carolina which will lessen the financial burden of healthcare costs on its economy and promote job growth.

Furthermore, more research is needed by the NC General Assembly Fiscal Research Division assessing the target gap coverage population and their medical management as a result of not expanding Medicaid. Perhaps these findings will promote an interest in the needs of this uninsured population and change the obstinate views of the opponents who are against Medicaid expansion.

APPENDIX A



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

CARRINGTON HALL
CAMPUS BOX 7460
CHAPEL HILL, NC 27599-7460
<http://nursing.unc.edu>

Date

Informed Consent Form:

I am being asked by Caprice Sylvan to participate in an undergraduate honors research project under the supervision of Shilda Rodgers, PhD, RN. By signing this form, I am agreeing to participate in the interview for the purpose of providing information for the research project: "Bridging the Gap: Addressing the need for North Carolina to accept the Affordable Care Act's Medicaid Expansion in order to close the gap between Medicaid and private insurance coverage of its uninsured adult population".

I understand that this interview will be voice recorded and may last no more than 60 minutes. By agreeing to be interviewed, I am consenting to disclose important information that has value to the research study. The research project has been fully explained to me, with my approval, and I was given the opportunity to ask questions about the study. I have read, I understand, and have been given a copy of this consent form. I understand the risks of revealing my identity to readers who are associated with and/or familiar with the type of information that I share. However, I have been told that, without exception, I will remain anonymous and that all transcripts, audio recordings, and personal identifiers from the interview will be kept private and secure by the researcher throughout the research and thereafter. Published reports of the completed study will not include my name. I understand and have been told that I may refuse to answer any questions during the interview and may terminate the interview upon my request at any time without any adverse consequences that may be damaging to my financial standing, employability, or reputation. I have been given the choice whether to participate in this research, and I possess the mental competence to make the choice to provide consent and sufficient information valuable to the research project. I have not been subject to undue influence or coerced to give my consent for research participation. It has been explained to me that there are no gifts or money given for participation in this research study.

I know that this research study has been approved by the University of North Carolina at Chapel Hill Institutional Review Board (IRB) and Office of Human Research Ethics. If I believe that my rights have been violated, then I will contact the institutional review board at 919-966-3113 or the faculty member supervising this project, Shilda Rodgers, PhD, RN at 919-843-2478.

Signature of participant

Participant's contact phone number

Date

Signature of person obtaining consent
Caprice Sylvan, Principal Investigator

Date

APPENDIX B

UNC
SCHOOL OF NURSING

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

CARRINGTON HALL
CAMPUS BOX 7460
CHAPEL HILL, NC 27599-7460
<http://nursing.unc.edu>

Current Date

Recipient Name

Recipient Address

Email Recruitment Announcement:

Greetings:

My name is Caprice Sylvan and I am a senior undergraduate student in the School of Nursing at the University of North Carolina. I am writing to invite you to be a participant in an honors research study "Exploring the extent to which North Carolina's denial of the Federal Medicaid expansion affected the healthcare management of North Carolina's uninsured and its population within the gap between Medicaid and private insurance coverage".

As a North Carolina resident, I am asking if you would participate in an interview involving this study. Participants will be asked a series of interview questions, which you will have access to before your interview date. The expected duration of the interview will be no longer than 60 minutes.

Participation is completely voluntary and all responses will be confidential and anonymous. Your participation, or decision not to participate, will in no way affect your professional or occupational standing.

I have attached a consent form detailing the interview process. If you choose to participate in the interview then please sign the consent form and return it back to me by date . You can mail or email it to me at:

526 Lake Royale
Louisburg, NC 27549
Email: casylvan@aol.com

Thank you very much.

Sincerely,

Caprice Sylvan
Principal Investigator
Bachelor of Science in Nursing Candidate
University of North Carolina at Chapel Hill, Class of 2015
Phone: 252-478-3795

APPENDIX C

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

CARRINGTON HALL
CAMPUS BOX 7460
CHAPEL HILL, NC 27599-7460
<http://nursing.unc.edu>

Date

Interview Questionnaire Survey:

- 1) How do you or your organization perceive the effects of NC's denial of Medicaid expansion on North Carolinians?
- 2) What effect did the denial of Medicaid expansion have on the use of care management in coordinating the continuum of patient care?
- 3) What changes in policy were made in nursing care management to accommodate those people in the gap coverage who were not eligible for Medicaid or the Affordable Care Act?
- 4) How are these people within the gap being medically managed and what resources are available to them?
- 5) If the government is not going to accept the Medicaid expansion, then what alternative plans do they have for ensuring that those in the gap have equal access to medical care? Please explain.
- 6) Do you think that the closing of rural hospitals have anything to do with NC's denial of Medicaid expansion? Does it even concern the politicians?
- 7) How is medical management of the rural populations affected by NC's denial of Medicaid expansion?
- 8) What were the reasons that NC denied Medicaid expansion? What are the reasons for supporting Medicaid expansion?
- 9) Are you for the approval or denial of Medicaid expansion and why?
- 10) Can you describe in detail any personal situation that you encountered or a case of someone else who may have been adversely affected by not being able to be approved for both NC Medicaid and the Affordable Care Act (Obamacare) health insurance?
- 11) Recently, it was reported that the North Carolina General Assembly's Fiscal Research staff presented information showing that North Carolina per capita spending on Medicaid has declined by over 11% since 2008. How is NC able to contain Medicaid costs? Do you think that accepting the Medicaid expansion would have a positive or negative effect on this and why? How do you think that we can accept Medicaid expansion and still contain the costs? Do you have any research data to support your thoughts?
- 12) What do you think that North Carolina should change or implement in order to close the gap between Medicaid and private insurance coverage so that everyone has fair access to health insurance?

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